Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NABIL BISHARA MD
10109 MCKALLA PLACE STE E
AUSTIN TX 78758

Respondent Name
INSURANCE CO OF THE STATE OF P

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-1316-01

MFDR Date Received
January 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim was reduced in error. This claim was for a Division ordered Designated Doctor Exam. We billed a total of $2,350.00 for this claim but were paid $1,000.00. The explanation given on the EOB justifying the denial states: *WORKERS' COMPENSATION STATE FEE SCHEDULE ADJUSTMENT; however, this is incorrect*. The reduction of parts of this claim is in violation of the rules of the Texas Department of Insurance Division of Workers' Compensation as this service was ordered on th DWC-32."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "AIG has reviewed the Medical Fee Dispute Resolution Request/Response (DWC-60). In reviewing the report, it is the carrier's position that the bill was paid correctly. The diagnosis is lesion of ulnar nerve and carpal tunnel. Even though both upper extremities are affected, it is one body area (upper extremities, lower extremities, spine/pelvis, etc).

MMI - $350

IR - $150

From report: "*Wrist/Elbows* – Her impairment rating is 0% whole person because there is no impairment rating for pain"."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 08, 2012	CPT Code 99456-W5-WP	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 20, 2012

   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 2 – The charge for this procedure exceeds the fee schedule allowance
   - 3 – This procedure is included in another procedure performed on this date

   Explanation of benefits dated August 27, 2012

   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 2 – The charge for this procedure exceeds the fee schedule allowance
   - 3 – This procedure is included in another procedure performed on this date

   Explanation of benefits dated January 03, 2013

   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 2 – The charge for this procedure exceeds the fee schedule allowance
   - 3 – This procedure is included in another procedure performed on this date

Issues

1. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Review of the submitted documentation finds a DWC-69 Report of Medical Evaluation and DWC-73 Texas Workers' Compensation Work Status Report. In further review of the Report for the disputed services by the examining doctor finds that the designated doctor addressed Maximum Medical Improvement (MMI), Impairment Rating (IR) and Return to Work (RTW) examinations with a 0% impairment rating whole person because there is no impairment rating for pain also DWC-69 form (Report of Medical Evaluation) in section IV Permanent Impairment, the doctor selected box b which states "I certify that the employee has permanent impairment as a result of the compensable injury. The amount of permanent impairment is 0%, which was determined in accordance with the requirements of the Texas Labor Code and Texas Administrative Code." The requestor billed services with CPT Code 99456-W5-WP. Reimbursement is in accordance with Chapter 28 Texas Administrative Code §134.204 which states "(j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows, (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include, (C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection, (3) The following applies for billing and reimbursement of an MMI evaluation, (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350, (4) The following applies for billing and reimbursement of an IR evaluation, (ii) The MAR for musculoskeletal body areas shall be as follows, (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used, (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area." CPT Code 99456-W5-WP is not supported as documentation does not support that impairment rating was performed using range of motion (ROM) or Diagnosis Related Estimate (DRE) method. Additional reimbursement is not allowed for CPT Code 99456-W5-WP.

2. The respondent issued payment in the amount of $1,000.00. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that no additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		March 17, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.